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Office of Administrative Law Judges
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Issue Date: 30 January 2007

In the Matter of:

J.B., Case No.: 2004-BLA-6558
Claimant

v.

CAMPBRANCH COAL COMPANY, INC.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

James D. Holliday, Esq.
Hazard, Kentucky
For the Claimant

David H. Neeley, Esq.
Neeley Law Office, P.S.C.
Prestonsburg, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners, who are totally disabled due to pneumoconiosis, and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on April 5, 2006, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") at 15. Director's Exhibits ("DX") 1-28, except for part of DX 20, Claimant's Exhibits ("CX") 1-5, and Employer's Exhibits ("EX") 1-5 were admitted into evidence without objection (Tr. 8-12). Part of DX 20 (Dr. Dahhan's medical report) was excluded because the Employer exceeded the limitations for the submission of evidence contained in the regulations and the Employer failed to show good cause for its admission.[1] However, Dr. Dahhan's x-ray reading, pulmonary function tests and arterial blood gas study accompanying the report were admitted. Tr. 6-8. The record was held open after the hearing to allow the parties to submit additional evidence and argument. I hereby admit the following additional exhibits which have been submitted timely by the parties: CX 5, the post-hearing deposition of Dr. George Caudill; EX 4, the May 22, 2006 report of Dr. Bruce Broudy; and EX 5, a reading of the x-ray taken January 26, 2004, by Dr. Dennis Halbert. The Claimant and the Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony at the hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his claim on May 23, 2003 (DX 2). The Director, OWCP, issued a Proposed Decision and Order denying benefits on March 31, 2004 (DX 22). The Claimant appealed and the claim was forwarded for a formal hearing on July 22, 2004 (DX 26).

APPLICABLE STANDARDS

Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2006). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203, and 718.204 (2006).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

[1] The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004), and that a party who fails to argue "good cause" when it seeks admission of excess evidence, waives the argument, *Brasher v. Pleasant View Mining Co.*, 23 B.L.R. 1- ___, BRB No. 05-0570 BLA (Apr. 28, 2005).

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

5. Whether the claim was timely filed.

6. Whether the named Employer is properly designated as Responsible Operator in this claim.

The Employer also reserved its right to challenge the statute and regulations (DX 26). At the hearing, the Employer withdrew the issue of dependency (Tr. 5), but the parties later reinstated the issue, as based on his testimony, the Claimant had no dependents (Tr. 22). The Employer stipulated to at least ten years of coal mine employment (Tr. 14).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant was born in 1943 (DX 2; Tr. 15). He completed the eighth grade (Tr. 26). The Claimant testified that he has no dependents for purposes of augmentation of benefits (Tr. 22; DX 10).

The Claimant's Employment History form lists coal mine employment from 1975 to 1989 and from 1990-1991 (DX 4). At the hearing, the Claimant testified that he worked 27 years in coal mine employment (Tr. 21). The Claimant's FICA earnings worksheet lists coal mine employment from 1960 to1963, 1966 to 1967, and 1980 to 1991 (DX 6). Based on Social Security earnings reports, I find that the Claimant has established 15 years of coal mine employment. On his Employment History, the Claimant stated that over the relevant period he was a foreman (DX 3, 4).

The Claimant testified that he has breathing problems, along with heart trouble, spleen, liver and pancreas ailments, which have been treated by Dr. Caudill for the past 10 to 11 years (Tr. 19). The Claimant testified that he has smoked since 1964 at a rate of 1-1/2 packs per day (Tr. 20). This testimony is supported by the physician records. I find, therefore, that the Claimant has a smoking history of two packs of cigarettes per day for a period of at least 40 years. The Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 3). Therefore, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). The Claimant said he had been receiving state black lung benefits, but they were exhausted by the time of the hearing.

Timeliness

Claims for benefits under the Act are accorded a statutory presumption of timeliness. § 718.308(c). A claim is timely filed if it was filed before three years after a "medical determination of total disability due to pneumoconiosis" is communicated to the miner. § 718.308(a); 30 U.S.C. § 932(f). The Board requires that under § 725.308(a), a written medical report, found to be probative, reasoned, and documented by the Administrative Law Judge,

indicating total respiratory disability due to pneumoconiosis, be communicated to the miner in such a manner that the miner was aware, or in the exercise of reasonable diligence, should have been aware, that he was totally disabled due to pneumoconiosis arising out of coal mine employment. *Adkins v. Donaldson Mine Co*., 18 B.L.R. 1-36, 1-42 (1993). Communication to the miner requires that a written report actually be received by the miner. *Id*. at 1-43. There is no evidence that the Claimant ever received a written report advising him that he had a total disability *due to pneumoconiosis* before he filed his claim.

The Fourth Circuit Court of Appeals disagreed with the Board and held that neither the Act nor the regulations require that the requisite notice to a claimant be in writing to trigger the statute of limitations. *Island Creek Coal Col. v. Henline*, 456 F.3d 421, 425-426 (4th Cir. 2006). I am not aware that the Sixth Circuit has spoken to the precise issue of written notification. However, in *Tennessee Consolidated Coal Co. v. Kirk,* 264 F.3d 602, 608 (6th Cir. 2001), the Court said that "[t]he three-year statute of limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis." At the hearing, the Claimant testified that Dr. Caudill had been treating him for lung and other problems for 10 to 11 years and, variously, that he was not sure whether Dr. Caudill ever told him that he had black lung (Tr. 23), and that Dr. Caudill told him that he was totally disabled by black lung disease two years after he started being treated (Tr. 25). Dr. Caudill's testimony at his deposition was equivocal and similarly inconclusive. He did not recall telling the Claimant that he was disabled due to pneumoconiosis, but said it would be consistent with his records. However, Dr. Caudill's testimony and treatment records suggest that he believed the Claimant to be disabled based on multiple impairments due to multiple causes, and involving multiple body organs; it appears that he did not single out the pulmonary or respiratory impairments in and of themselves as a cause of disability when treating the Claimant (*see* CX 3 and CX 4 at 8). He was not asked to give an opinion in connection with the Claimant's black lung claims when he first started treating the Claimant, because the Claimant was already receiving state benefits,[2] and had not yet filed his federal claim. I conclude that the evidence as to when the Claimant was told he was disabled due to pneumoconiosis is insufficient to overcome the presumption that the claim was timely filed.

I, therefore, find that the claim for benefits is timely filed.

Responsible Operator

Section 725.493 provides that the operator of or other employer with who the miner had the last recent cumulative employment of not less than one year shall be considered the responsible operator. For purposes of § 725.493(a), one year of coal mine employment may be established by accumulating intermittent periods of coal mine employment. Thus, a named operator is the responsible operator where (1) the operator is the miner's most recent employer, and (2) the miner's cumulative employment with the operator amounted to more than one year, even where the Claimant worked for a different employer in between his work with the operator. *Snedecker v. Island Creek Coal Co.,* 5 BLR 1-91 (1982). The record contains a submission by

[2] The evidence is contradictory whether the Claimant filed for or received state benefits. The Claimant testified that he received state benefits before he began seeing Dr. Caudill, but they had run out by the time of the hearing. Tr. 25-26. While his claim was pending before the District Director, he indicated on a form that he had not filed for state benefits (DX 9). Either way, there is no evidence that Dr. Caudill was asked for an opinion in connection with any state claim.

the Employer stating that the Claimant worked for Campbranch Coal Company, Inc., from September 1990 through September 30, 1991 as a supervisor foreman (DX 7, 8). The Claimant's FICA earnings worksheet lists coal mine employment from 1960 to1963, 1966 to 1967, and 1980 to 1991 (DX 6). As both FICA earnings and the Employer's submission establish that the Claimant worked his last full year of coal mine employment with Campbranch Coal Company, Inc., I find that the named Employer is properly named as responsible operator in this claim.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim. X-ray interpretations submitted by the parties in connection with the current claim are in accordance with the limitations contained in 20 CFR § 725.414 (2006).

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, and 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians who classified opacities observed on x-ray have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), and/or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[3] Qualifications of physicians are abbreviated as follows: B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S.

[3] NIOSH is the Federal Government Agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK LUNG/REFERENCES/REFERENCE WORKS/BREAD3 08 05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the website of the American Board of Medical Specialties found at http://www.abms.org.

135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
02/25/94			A. Patel (CX 3) Left pleural efusión probable post surgical. Status post CABG. No active cardiopulmonary disease.
05/09/94			A. Patel (CX 3) Status post CABG. Borderline cardiomegaly. No active cardiopulmonary disease.
09/26/96			Caton (CX 3) Lungs are clear.
01/13/03			Datu (CX 3) No active lung disease changes.
02/04/03			Pietan/Mikhail (CX 3) Clear lungs.
07/17/03	Alexander, B/BCR (CX 1) 1/0 M. Patel, B/BCR[4] (DX 12) 1/0	Halbert, B/BCR (DX 21) 0/0	Barrett, B/BCR (DX 13) Read for quality only; Quality 1.
01/26/04	Alexander, B/BCR (CX 2) 1/0	Halbert, B/BCR (EX 5) 0/0 Dahhan, B (DX 20) Negative	
02/17/05			Limbaugh (CX 3) No acute disease. Probable COPD.
11/22/05			Buck (CX 3) Emphysema and mild cardiomegaly

[4] Much discussion was given to Dr. Patel's status as a B reader during Dr. Rasmussen's deposition (CX 4). According to the NIOSH list, Dr. Patel was a registered B Reader from Feb 1, 1997 to Jan 31, 2001 and from February 1, 2001, to January 31, 2005. Therefore, his July 17, 2003, interpretation took place when he was qualified as a Board-certified Radiologist and B reader, and I weight it appropriately under those conditions.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991).

A CT scan without contrast was taken of the Claimant's chest on February 7, 2003. The Radiologist, Dr. DePeri, observed bilateral scattered central and peripheral nonspecific patchy parenchymal areas of opacity with associated diffuse bronchiectasis. The findings were suggestive of inflammatory or infectious process. There were no parenchymal nodules.

A CT scan with contrast was taken of the Claimant's chest on December 1, 2005, due to his shortness of breath. The Radiologist, Dr. Buck, gave an impression of mild interstitial changes.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1), and maximum voluntary ventilation (MVV).

The following chart summarizes the results of submitted pulmonary function studies available with the current claim. Pulmonary function studies submitted by the parties in connection with this claim are in accordance with the limitations contained in 20 CFR § 725.414 (2006). "Pre" and "post" refer to administration of bronchodilators. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height**[5]	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 13 07/17/03 Rasmussen	60 69"	1.91 2.47	2.88 3.48	66% 71%	62 104	Yes No	Moderate significantly reversible obstructive impairment. Invalid per Dr. Burki.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 68" to 69", I have taken the mid-point (68.5") in determining whether the studies qualify to show disability under the regulations. The pre-bronchodilator test administered by Dr. Dahhan on January 26, 2004, resulted in a qualifying value if Claimant is 69" tall.

Ex. No. Date Physician	Age Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 12 12/02/03 Rasmussen	60 69”	1.89 2.18	3.03 3.33	62% 66%	Not performed	No No	Moderate partially reversible airway obstruction. Restrictive component not entirely excluded.
DX 20 01/26/04 Dahhan	60 173 cm (68”)	1.96 2.04	2.62 2.71	75% 75%	57 60	No No	Moderate obstructive defect.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. Arterial blood gas studies submitted by the parties in connection with the claim are in accordance with the limitations contained in 20 CFR § 725.414 (2006). A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
CX 3	12/02/02	Not identified	41.3	74.01	No	Mild hypoxemia
DX 12	07/17/03	Rasmussen	39	55	Yes	Minimal resting hypoxemia.
DX 20	01/26/04	Dahhan	43.9 43.1	69.4 69.7	No No	Mild hypoxemia at rest. No change with exercise. Exercise terminated due to fatigue.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be, nevertheless, found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions relating to this case.

The record contains the treatment notes of Dr. Caudill dated 1993 to February 2006 (CX 3). Handwritten notes from 1993 to 1997 are largely illegible. Medical histories taken in connection with consultations for abdominal and chest pain in 1994 and 1995 indicate that the Claimant's heart disease dated to February 1994, with coronary bypass grafting in February 1995. Diagnoses in the consulting reports included tobacco abuse and COPD with bronchitis. In recent years, Dr. Caudill noted 10 ailments afflicting the Claimant including heart failure, ascites, edema, splenomegaly, abdominal pain, chest pain, aortocoronary bypass, chronic pancreatitis, essential hypertension, and type II diabetes. Over time, the Claimant was prescribed from 20 to 40 different medications to treat these maladies. Singulair, an asthma medication, was also included; Dr. Caudill's notes usually reflected no asthma upon examination. The most recent records reflect shortness of breath and wheezing, but no other pulmonary symptoms, and indicate that the Claimant was still smoking one pack per day. Chest examination revealed diffuse rhonchi and decreased breath sounds. The records reflect that the Claimant's smoking declined over the years from two packs per day to one or less. Dr. Caudill repeatedly advised the Claimant to stop smoking.

The Claimant was hospitalized from October 29 to 31, 2005, after reporting to the emergency room with increasing shortness of breath (CX 3). The history noted "a long-standing history of coal worker's pneumoconiosis as well as COPD." The Claimant reported being on home oxygen, and that he still smoking about half a pack of cigarettes per day. He was treated with nebulizer treatment and steroids, and received a transfusion. Chronic obstructive pulmonary disease was listed first among the discharge diagnoses.

Dr. Caudill was deposed by the Claimant on April 6, 2005 (CX 5). He is a general practitioner. Dr. Caudill stated that he had treated the Claimant from 1993 to the present. In his first visit, the Claimant complained of lung problems, gave a history of coal dust exposure, and relayed a history of back and abdominal pains and a previous cardiac bypass surgery. He noted 17 years of coal mine employment and noted a smoking history of two packs per day since the 1960's with continued smoking. The Claimant described his coal mine employment as heavy manual labor requiring lifting and carrying of up to 100 lbs. Dr. Caudill diagnosed a chronic dust disease of the lungs, demonstrated by chronic obstructive pulmonary disease, smothering spells, and the history of coal dust exposure. He opined that the COPD was due to both cigarette smoking and coal dust exposure, and stated that cigarette smoking was approximately 75% of the cause of the Claimant's impairment. He based his percentage on the heavy smoking history with ongoing smoking. He attributed approximately 25% of the Claimant's impairment to coal dust exposure due to the number of years of exposure and the fact that dust exposure had ceased while cigarette smoking continued. Dr. Caudill stated that the Claimant is totally disabled from resuming his heavy manual labor of his previous position. He based this on pulmonary function studies, the nature of the Claimant's previous employment, and his physical examinations of the Claimant.

Dr. D.L. Rasmussen, a Board-certified Internist, Pulmonologist, and B reader, examined the Claimant on July 17, 2003 (DX 12). Based on symptomatology (short of breath, cough, wheeze, orthopnea, PND, ankle edema), employment history (27 years coal mine employment), individual and family histories (CABG, hypertension), smoking history (40 plus years, between 1-1½ packs per day), physical examination (breath sounds moderately reduced, widespread rales and rhonchi), chest x-ray (1/0 by Dr. Patel), pulmonary function study (moderate, significantly reversible obstructive ventilatory impairment), arterial blood gas study (hypoxia), and an EKG (normal), Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on a positive x-ray and a history of coal dust exposure. He opined that objective testing indicated a moderate impairment of respiratory function, and he opined that the Claimant no longer retained the pulmonary capacity to perform his last regular coal mine job. He listed the etiology of the Claimant's disability as a combination of cigarette smoking, coal dust exposure, possible asthma, as well as cirrhosis of the liver.

Dr. Rasmussen was deposed by the Claimant on March 22, 2006, when he repeated the findings in his earlier written report (CX 4). He was asked to assume that the Claimant had 13 years of coal mine employment, and a smoking history of up to two packs per day since the 1960's. He opined that while Claimant's pulmonary function testing did not meet the Federal disability standard, the Claimant's last coal mine job as a supervisor consisted of a "good deal of heavy and some very heavy manual labor… [and] he does not retain the pulmonary capacity to perform his last regular coal mine job." Asked whether the Claimant has coal workers' pneumoconiosis, he said that he believed the Claimant has some coal mine dust induced chronic lung disease, or COPD. He considered the Claimant's coal dust exposure a lesser contributing factor than smoking or asthma, but said it would constitute a significant portion of the impairment. He opined that smoking and coal mine dust cause some of the identical abnormalities, and therefore, it is impossible to quantify a certain percentage to one cause or the other. He then discussed a host of other ailments, unrelated to coal dust exposure, which afflict the Claimant including liver disease, enlargement of the spleen and heart disease. He agreed that the Claimant would be disabled even without his pulmonary impairment. He reiterated that the

pulmonary impairment alone would also be sufficient to prevent the Claimant to perform heavy or very heavy manual labor.

Dr. B.T. Westerfield, a Board-certified Internist, Pulmonologist, and B reader, performed a January 24, 2006, records review at the request of the Employer (EX 2). He opined that a majority of B readers interpreted the x-ray evidence as negative for pneumoconiosis. He opined that pulmonary function testing showed significant medical problems including obstructive lung disease caused by cigarette smoking and symptoms of asthma. He noted the reversibility shown in pulmonary function testing demonstrated asthma. He stated that the Claimant's medical ailments and impairment were not caused by or aggravated by coal dust exposure. He opined that pulmonary function testing and arterial blood gas readings demonstrate that the Claimant is not totally disabled from returning to his previous coal mine employment.

Dr. Bruce C. Broudy, a Board-certified Internist, Pulmonologist, and B reader, performed a January 17, 2006, records review at the request of the Employer (EX 1). Dr. Broudy opined that x-ray evidence did not support pneumoconiosis. In his opinion, Dr. Patel's observation of small irregular opacities was more typical of asbestosis or peribronchial fibrosis from smoking, and not indicative of pneumoconiosis. He opined that pulmonary function and arterial blood gas readings indicate that the Claimant has obstructive airways disease from cigarette smoking and no dust disease of the lung. He further opined that any pulmonary and/or respiratory disability can be explained by cigarette smoking alone. Dr. Broudy stated that medical records reflect that the Claimant has significant impairment, but they do not demonstrate total disability, as most results exceed the minimum federal criteria for disability in coal workers.

Dr. Broudy submitted an April 11, 2006 report (EX 3) reviewing the opinion of Dr. Rasmussen (CX 4). Dr. Broudy opined that Dr. Rasmussen's diagnosis of a reversible pulmonary condition is not consistent with occupationally induced lung dysfunction. Impairment due to coal dust exposure is usually irreversible and usually restrictive, although it can be a mixed defect. He stated that it is well-known that cigarette smoking causes an obstructive defect, the type of impairment that Dr. Rasmussen noted. He opined that it was medically improbable that Claimant's impairment was due to the inhalation of coal mine dust. He also opined that coal dust exposure was not a substantial or consequential cause of the Claimant's pulmonary impairment.

Dr. Broudy submitted a third written report dated May 22, 2006 (EX 4). In his final report, Dr. Broudy responded to the deposition of Dr. Caudill (CX 5). Dr. Broudy stated that review of newer medical evidence demonstrated "no more than very early simple pneumoconiosis" and that it would be improbable that any measurable impairment would be due to pneumoconiosis.[6] He instead attributed the Claimant's impairment demonstrated by smothering spells and chronic obstructive pulmonary disease to the results of cigarette smoking and "some predisposition to asthma or bronchospasm." He opined that the results of more recent studies showed "significant impairment" which meet the Federal criteria for disability in coal workers. He based his smoking only impairment etiology on the fact that the impairment was at least partially reversible, which was inconsistent with most pulmonary disease caused by coal mine dust.

[6] It is unclear from Dr. Broudy's letter which evidence he relied upon to diagnose possible early simple pneumoconiosis. It appears that he may have been referring to the CT scans, or the positive x-ray readings.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006). In this case, the Claimant's medical records indicate that he has been diagnosed with pneumoconiosis, as well as chronic obstructive pulmonary disease which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal mine dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after

January 1, 1982), or 718.306 (applicable only to deceased miners); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the Claimant has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at § 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148 to 1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The record includes seven x-rays taken during medical treatment which do not mention pneumoconiosis, and are not classified as required by the regulations. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). The five x-rays taken between 1994 and 2003 were read as clear, or showing no active cardiopulmonary disease. I find all of these x-rays to be negative. The two most recent x-rays, taken in 2005, both show chronic obstructive pulmonary disease. These x-rays should not be interpreted as negative.

There are only two x-rays which have been read for pneumoconiosis in connection with the claim. They were taken only six months apart. The July 17, 2003, x-ray film was read as positive by Dr. Alexander and Dr. Patel, both dually certified, and as negative by Dr. Halbert, who is also dually certified. I give greater weight to the two positive readings by dually certified physicians over the one negative reading and find that the July 17, 2003, x-ray evidence is positive for pneumoconiosis.

The January 26, 2004, x-ray film was read as positive by Dr. Alexander, a Board-certified Radiologist and B reader, and as negative by Dr. Halbert, a Board-certified Radiologist and B reader, and by Dr. Dahhan, a B reader. I give greater weight to the two negative readings and find that the January 26, 2004, x-ray evidence is negative for pneumoconiosis.

Of the two x-rays taken in connection with the claim, there is one positive and one negative film. The record contains three positive and three negative readings of these two films, taken close in time. The qualifications of the interpreting physicians are comparable. I find that the x-ray evidence fails to establish the existence of pneumoconiosis by a preponderance of the evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*).

The Department of Labor has taken the position that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. This underlying premise was stated explicitly in the commentary that accompanied the final version of the current regulations. The Department concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. **The risk is additive with cigarette smoking**." 65 Fed. Reg. at 79940 (emphasis added). Citing to studies and medical literature reviews conducted by NIOSH, the Department quoted the following from NIOSH:

> … COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. **Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present**.…

65 Fed. Reg. at 79943 (emphasis added). Moreover, the Department concluded that the medical literature "support[s] the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms." I have considered how to weigh the conflicting medical opinions in this case based on these premises.

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the

nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2006). The Sixth Circuit has interpreted this rule to mean that:

> … in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade …. For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2003) (citations omitted).

Dr. Caudill was the Claimant's treating physician. "[T]he opinions of treating physicians are not necessarily entitled to greater weight than those of non-treating physicians in black lung litigation." *Eastover Mining Co. v. Williams*, 338 F.3d 501 (6th Cir. 2003). "[I]n black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade." *Id*. at 510; 20 C.F.R. § 718.104(d). "A highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinion appropriately discounted." *Id*. In addition, appropriate weight should be given as to whether the treating physician's report is well-reasoned and well-documented. *See Peabody Coal Co. v. Groves*, 277 F.3d 829 (6th Cir. 2002); *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2-108 (11th Cir. 1988).

Dr. Caudill is a family practitioner, with no special qualifications so far as the record shows, but he has treated coal miners in his practice. He diagnosed chronic dust disease of the lungs, as demonstrated by pulmonary function testing, smothering spells suffered by the Claimant, and the history of coal dust exposure. He diagnosed the etiology of the Claimant's lung disease as cigarette smoking and coal dust exposure. He correctly noted the Claimant's smoking history and coal mine employment history. He opined that ongoing and heavy cigarette smoking suggested that the Claimant's obstructive defect was predominately caused by cigarette smoking, and he opined that the lengthy but discontinued coal dust exposure resulted in about 25% of the Claimant's disease. Dr. Caudill treated the Claimant for approximately 13 years for a wide range of ailments. I find that he has extensive experience in treating the Claimant and has a firm ongoing understanding of the Claimant's physical condition. He documented which readings supported his opinion and he explained in detail which etiologies he deemed realistic and assigned 25% of the Claimant's lung disease to coal dust exposure. While Dr. Caudill's credentials are not in the record, I find his opinion is based on objective testing, based on 13 years of extensive treatment, and I find that he is well reasoned. I give Dr. Caudill's opinion great weight towards a finding of legal pneumoconiosis.

Dr. Rasmussen, a Board-certified Internist, Pulmonologist, and B reader, initially diagnosed coal workers' pneumoconiosis on the basis of a positive x-ray and a history of coal dust exposure. At his deposition, however, he said that while Dr. Patel read the x-ray as positive, 1/0, as a B reader himself, he would classify it as 0/1. He relied on Dr. Patel's reading at the

time he issued his report, because he understood that the Department of Labor prefers readings by dually qualified readers. He also opined that pulmonary function testing showed a moderate, significantly reversible ventilatory defect. He opined that the obstructive impairment was caused by a combination of cigarette smoking, coal dust exposure, possible asthma, and cirrhosis of the liver. In his deposition, he explained how he arrived at a possible diagnosis of asthma, and explained that coal dust exposure and cigarette smoking cause a number of identical abnormalities. In his opinion, therefore, it is impossible given the ongoing smoking and lengthy coal dust exposure to quantify the objective impairment seen as being totally due to one cause or the other. It was his opinion that smoking was likely the more significant causation while coal dust exposure was a lesser and possibly aggravating cause of the Claimant's lung disease. He then explained how the Claimant's other ailments could have impacted the Claimant's objective testing.

Dr. Rasmussen's diagnosis of obstructive lung disease caused at least in part by coal dust exposure, *i.e.*, legal pneumoconiosis, is well reasoned. He documents which objective testing demonstrates the obstructive defect, and then explains in detail how smoking, coal dust, possible asthma, and unrelated ailments could have influenced the Claimant's pulmonary function readings. While the Employer argues in its brief that Dr. Rasmussen initially based his opinion on an inaccurate smoking and coal dust history, when asked to reevaluate his opinion with the correct exposure histories, Dr. Rasmussen took that information into account in diagnosing legal pneumoconiosis. I give Dr. Rasmussen's diagnosis of obstructive lung disease great weight towards a finding of legal pneumoconiosis.

Dr. Westerfield, a Board-certified Internist, Pulmonologist, and B reader, opined that pulmonary function testing showed obstructive lung disease caused by cigarette smoking and symptoms of asthma. He opined that the reversible nature of the impairment supported a finding of asthma, but he did not explain why cigarette smoking caused the impairment seen and did not explain why coal dust exposure did or did not contribute to the obstructive defect seen. An opinion which fails to adequately address all possible forms of causation is undocumented, unreasoned, and of little or no probative value. *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. Apr. 5, 2004)(unpub). I find that Dr. Westerfield's diagnosis of obstructive lung disease is based on objective testing and I give it great weight. I find that Dr. Westerfield's diagnosis of a smoking etiology is not well reasoned, and I give it less weight.

Dr. Broudy, a Board-certified Internist, Pulmonologist, and B reader, opined that the Claimant suffers from an obstructive airways disease caused by cigarette smoking alone. He cited the obstructive nature of the impairment, objective testing results, and the generally irreversible nature of coal dust related lung disease as supporting his smoking only etiology. He then reviewed the reports of Drs. Rasmussen and Caudill. Dr. Rasmussen's report did not change his earlier diagnosis and opinion. In response to Dr. Caudill's report, Dr. Broudy stated the medical evidence in this report demonstrated "no more than very early simple coal workers' pneumoconiosis" and that it was improbable that any impairment was due to pneumoconiosis. He cited the partially reversible nature of the Claimant's defect as supporting a cigarette etiology. Dr. Broudy's report is based on objective evidence but Dr. Broudy hedges his diagnoses and opinions. In review of Dr. Patel's positive x-ray interpretation, he opines that the opacities seen were "more typical" of other ailments. He noted that impairment due to coal dust is "usually" irreversible and restrictive, but doesn't explain why *this* obstructive defect was not caused, at least in part, by coal dust exposure. By the time he reviews Dr. Caudill's report, he

states that the records review showed "no more than very early coal workers' pneumoconiosis." While I find that Dr. Broudy based his report on objective testing, I find his opinion not as well reasoned as other opinions which more completely deal with the combination of a lengthy smoking habit and multiple years of coal dust exposure. I give his opinion great weight towards a finding of obstructive lung disease, but less weight on the etiology of the obstructive defect shown.

Taken as a whole, I find that all medical reports of record objectively diagnose obstructive lung disease. I find most credible the etiology opinions of Drs. Rasmussen and Caudill, which find that the Claimant's obstructive lung disease is caused by a combination of heavy smoking and extensive coal dust exposure. I find that the Claimant has established the existence of legal pneumoconiosis under the regulations.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). The Claimant was employed as a miner for 15 years and, therefore, is entitled to the presumption. The Employer has not offered evidence to rebut the presumption. Recently the 10th Circuit Court of Appeals held that the presumption applies only when the miner has established that he has clinical pneumoconiosis. *Anderson v. Director, OWCP*, 455 F.3d 1102 (10th Cir. 2006). In this case, I have found that the Claimant has established that he has legal, but not clinical, pneumoconiosis. I also find that he has established a causal relationship between his disease and his coal mine employment through the opinions of Dr. Caudill and Dr. Rasmussen. I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Disability Due to Pneumoconiosis

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(i)and (ii). The claimant must establish by a preponderance of the evidence that his pneumoconiosis was at least a contributing cause of his total disability. *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986) (*en banc*). Total disability can be established pursuant to one of the four standards in § 718.204 (b)(2) or through the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).

Section 718.204(b)(2)(i) permits a finding of total disability when there are pulmonary function studies with FEV_1 values equal to or less than those listed in the tables and either:

1. FVC values equal to or below listed table values; or,
2. MVV values equal to or below listed table values; or,
3. A percentage of 55 or less when the FEV_1 test results are divided by the FVC test results.

The record contains three pulmonary function studies, as the first test performed on behalf of the Department of Labor was ruled invalid. The fact-finder must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.,* 9 B.L.R. 1-131 (1986).

It is important to note, however, that in *Crapp v. U.S. Steel Corp*., 6 B.L.R. 1-476 (1983), the Board held that a nonconforming pulmonary function test may be entitled to probative value where the results exceed the table values, *i.e.*, the test is nonqualifying. As the Board noted, "[d]espite any deficiency in cooperation and comprehension, the demonstrated ventilatory capacity was still above the table values. Had the claimant understood or cooperated more fully, the test results could only have been higher." Dr. Burki, a Board-certified Internist and Pulmonologist, opined that Dr. Rasmussen's tests were invalid due to suboptimal effort (*See* DX 12). I note that Dr. Rasmussen's test produced nonqualifying results, and I find that had the Claimant participated with greater effort, the results could only have been higher. I give Dr. Rasmussen's first pulmonary function test weight in determining total disability.

Both of Dr. Rasmussen's pulmonary function tests administered in 2003 produced nonqualifying readings. Dr. Dahhan's 2004 test also produced non-qualifying readings if his measurement of the Claimant's height as less than 69" is taken into account. I find that total disability is not established under § 718.204(b)(2)(i). Nonetheless, I note that Dr. Dahhan's test result was very close to a qualifying value before the administration of bronchodilators.

Total disability may be found under § 718.204(b)(2)(ii) if there are arterial blood gas studies with results equal to or less than those contained in the tables. The record contains three arterial blood gas studies. The first, administered during treatment in 2002, was nonqualifying. Dr. Rasmussen's test produced qualifying readings. Dr. Dahhan's 2004 test produced nonqualifying readings. More weight may be given to the results of a recent arterial blood gas study over a study that was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). I give greater weight to the more recent test of Dr. Dahhan and find that total disability is not established under § 718.204(b)(2)(ii).

There is no evidence presented, nor do the parties contend that the Claimant suffers from cor pulmonale or complicated coal workers' pneumoconiosis.

Under § 718.204(b)(2)(iv) total disability may be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

Dr. Caudill treated the Claimant for over 13 years on an ongoing basis. He opined that the Claimant's chronic obstructive pulmonary disease, when reviewed with the requirements of the Claimant's last position, was totally disabling. Noting ongoing heavy smoking with an extended but discontinued coal dust exposure history, Dr. Caudill opined that coal dust exposure represented approximately 25% of the cause of Claimant's total disability. Dr. Caudill had 13 years ongoing treatment of overlapping ailments and he correctly noted employment history, smoking history, and the requirements of the Claimant's last position. I find Dr. Caudill's opinion well reasoned and based on objective testing. I find his opinion that the Claimant's disability was caused, at least in part, by coal mine employment, to also be well reasoned supporting a finding of total disability due at least in part to pneumoconiosis.

Dr. Rasmussen opined that pulmonary function testing and arterial blood gas testing showed moderate impairment, and he opined that the Claimant no longer retained the pulmonary capacity to perform his previous coal mine employment. He listed the etiology of the Claimant's impairment as a combination of ongoing heavy smoking, coal dust exposure, possible asthma and a host of other ailments unrelated to coal mine employment. He utilized the Claimant's previous work requirements and explained why he believed extended coal dust exposure was a measurable portion of the Claimant's impairment. Dr. Rasmussen utilized objective evidence in his diagnosis of total disability. He explained in his deposition how cigarette smoking, coal dust exposure and unrelated other abnormalities interacted to produce the disability diagnosed. I find that Dr. Rasmussen's report is well reasoned, based on objective evidence, and I afford it great weight towards total disability. I find his etiology opinion well reasoned stating that coal dust exposure was a significant factor in the Claimant's total disability.

Dr. Broudy submitted three sequential reports. By the third report on May 22, 2006, Dr. Broudy stated that newer medical testing showed "significant impairment" which meets the Federal criteria for disability in coal workers. He based his opinion on pulmonary function testing and arterial blood gas tests. Dr. Broudy's diagnosis of total disability is based on objective testing and I find his diagnosis of total disability well reasoned.

Dr. Broudy maintained his earlier opinion that because the impairment was partially reversible, it was caused entirely by ongoing cigarette smoking and not by coal dust exposure. In *Consolidation Coal Co v. Swiger,* Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.), the Court upheld the ALJ's finding that reversibility of pulmonary function values after use of a bronchodilator does not preclude the presence of disabling coal workers' pneumoconiosis. In particular, the Court noted that:

> All the experts agree that pneumoconiosis is a fixed condition and therefore any lung impairment caused by coal dust would not be susceptible to bronchodilator therapy. In this case, although [the Claimant's] condition improved when given a bronchodilator, the fact that he experienced a disabling residual impairment suggested that a combination of factors was causing his pulmonary condition. As a trier of fact, the ALJ 'must evaluate the evidence, weigh it, and draw his own conclusions.' (citation omitted). Therefore, the ALJ could rightfully conclude that the presence of the residual fully disabling impairment suggested that coal mine dust was a contributing cause of [the Claimant's] condition.

Drs. Rasmussen and Caudill noted that cigarette smoke and coal dust cause many of the same types of abnormalities and opined that it is impossible medically to distinguish exact causation when both conditions exist. Dr. Broudy fails to account for the remaining impairment after administering bronchodilators, and his smoking-only etiology is not well explained in his opinion. I find Dr. Broudy's smoking-only etiology to not be well reasoned.

Dr. Westerfield opined that pulmonary function and arterial blood gas testing did not demonstrate total disability, and he listed the etiology of the Claimant's impairment as cigarette smoking with symptoms of asthma. He failed to address how coal dust exposure was not a possible cause of the Claimant's impairment. An opinion which fails to adequately address all possible forms of causation is undocumented, unreasoned, and of little or no probative value. *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub) (holding that a physician's opinion that total disability was due to smoking was unreasoned where he failed to explain "how he eliminated nearly thirty years of exposure to coal mine dust as a possible cause" of the miner's pulmonary impairment); *see also, Barnes v. Director*, OWCP, 19 B.L.R. 1-71 (1995). Dr. Westerfield reviewed objective testing but he did not take into account the physical requirements of the Claimant's last coal mine employment. I find Dr. Westerfield's opinion to be unreasoned and unsupported. I give his opinion on total disability less weight. Moreover, as he did not find the Claimant to be disabled, he did not proffer any opinion on the cause of disability.

As a result of near-qualifying pulmonary testing, and the well-reasoned opinions of Drs. Rasmussen and Caudill stating that the Claimant suffers from total pulmonary or respiratory disability, I find that the evidence establishes total disability under § 718.204(b)(2). Regarding etiology of the Claimant's total disability, I give greatest weight to the better reasoned opinions of Drs. Rasmussen and Caudill over the contrary opinions of record, and find that pneumoconiosis was a contributing, aggravating cause of the Claimant's total disability.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. 20 CFR § 725.503(b) (2006); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits in May 2003. When he was examined by Dr. Rasmussen in July 2003, he was already totally disabled. The record does not establish when he first became disabled, however. Although Dr. Caudill agreed that the Claimant was disabled by the lung impairment, he did not give any particular date of onset of disability from that cause.

I find that the Claimant is entitled to benefits commencing in May 2003, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

As the Claimant has established that he is totally disabled by a pulmonary or respiratory impairment caused, in part, by pneumoconiosis, he is entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2006). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by the Claimant on May 23, 2003, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).